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# RECOMMENDATION FOR ADDITIONAL GENERAL RESOURCES TO FUND THE APPROVED COUNTRY PROGRAMMES IN THE AFRICA, ASIA AND MIDDLE EAST AND NORTH AFRICA REGIONS*

SUMMARY

The present document contains recommendations for additional general resources to fund the approved country programmes in the Africa, Asia and Middle East and North Africa regions for which the balances of approved general resources are not sufficient to fund the programmes up to the approved programme periods. The Executive Director recommends that the Executive Board approve additional general resources in the following amounts, totalling $15,189,000, to achieve the objectives of the country programmes as originally approved by the Board.

| Country/programme | Amount (United States dollars) | Current programme cycle |
|---|---|---|
| Benin | 949 000 | 1990-1994 |
| Botswana | 2 105 000 | 1990-1994 |
| Egypt | 4 450 000 | 1990-1994 |
| Maldives | 430 000 | 1990-1994 |
| Niger | 2 695 000 | 1990-1994 |
| Philippines | 1 060 000 | 1991-1993 |
| Syrian Arab Republic | 2 000 000 | 1991-1995 |
| Thailand | 1 500 000 | 1989-1993 |

Annual funding requirements of the eight countries are provided in the table.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/P/L.2 and Add.1).

# I. BENIN

1. The country programme for Benin for the period 1990 to 1994 was approved by the Executive Board in 1989 with available general resources of $4,455,000 (E/ICEF/1989/P/L.4). In 1992, the annual planning level was increased to $1.1 million, which reinforced programme activities but also resulted in constraints in the availability of general resources for 1994, the last year of the current programme. As a result, the Benin country programme requires additional general resources of $949,000 for the first half of 1994, until a new country programme for mid-1994 to 1998 can be submitted to the 1994 Executive Board. A UNICEF programme cycle from 1994 to 1998 would be synchronized with the programme cycle of the United Nations Development Programme (UNDP) and have the longer-term objective of greater inter-agency collaboration.

2. Since the start of the current country programme, there have been positive changes in Benin, brought about by renewed democratic processes in the country. There has been greater impetus to social development, as witnessed by the support for human development in the programme of structural adjustment; by the country's commitment to the goals of the World Summit for Children and the International Conference on Assistance to African Children, which established intermediate goals for 1995; and the subsequent elaboration of a national programme of action (NPA). In spite of some obstacles typical of countries undergoing the transition to democracy and problems in the subregion, Benin has gained considerable support for its efforts to make democracy viable. This understanding has been expressed in terms of increased aid, mainly for the social sectors, and a substantial restructuring of international debt.

3. The first programme of structural adjustment caused modifications in the overall economic environment and resulted in a general slowing of economic growth, with worsening internal and external financial imbalances and unemployment and, concurrently, negative effects on the poorest and the most vulnerable segments of the population, especially women and children. Subsequently, the second (and current) programme of structural adjustment took into account the dimensions of social development discussed at the round table held at Geneva in April 1992.

4. The mid-term review of the current country programme took place in July 1992 and allowed for a reformulation of objectives, taking into account the goals elaborated in the NPA.

## Health

5. Health sector activities have been predominant in the country programme, and there has been reasonable success. In 1990, the year of universal child immunization (UCI), immunization coverage rates for three doses of combined diphtheria/pertussis/tetanus vaccine reached 77 per cent and for measles 50 per cent. There was a slight drop in coverage rates in 1991, but the 1990 rates were re-established during 1992. The recovery was due in large part to the existence of health management committees at the commune level in the health centres covered by the primary health care (PHC)/Bamako Initiative component of the health programme. The major challenges now are to consolidate gains made in the health centres; to improve the management skills of commune committees and

supervision skills at all levels; to go substantially beyond the expanded programme on immunization (EPI) and support to basic health services; and to include other social sector priorities in the next country programme.

6. The "baby-friendly" hospital initiative has been relatively successful, with two hospitals declared "baby-friendly" by the end of 1992. UNICEF contributed to the elaboration of a national programme for the control of acute respiratory infections (ARI). The control of diarrhoeal diseases (CDD), one of the major causes of morbidity and mortality, has been given more emphasis with an increase in training activities and the installation of oral rehydration therapy (ORT) units. Information, education and communication (IEC) activities have been the major intervention for the control of acquired immune deficiency syndrome (AIDS).

Nutrition

7. Activities in the area of nutrition have included the promotion of protein-enriched soya weaning foods and the identification of micronutrient-poor areas for intensive interventions. The mid-term review recommended that nutrition surveillance be reinforced through the development of community-based nutrition information systems that would permit communities to identify and analyse the causes of malnutrition and take appropriate action. Zou Province, where nutrition problems are particularly serious, has been selected for the initial intervention.

Water supply and environmental sanitation

8. The implementation of the rural water supply and environmental sanitation programme was intensified, with special emphasis on activities related to the eradication of dracunculiasis (guinea worm disease), particulary in Zou Province, where the annual incidence of the disease is high. The establishment of health development committees for the maintenance of pumps in villages has contributed to the high rate of pumps functioning (93 per cent). These committees also are responsible for the diffusion of educational health messages in villages. Other linkages with the health sector include the maintenance of vehicles for EPI, transport of material and management of spare parts at the base office in Bohicon, the duty station of the UNICEF personnel responsible for water supply activities. In addition, 217 school and household latrines have been constructed. Related activities include the establishment of garden plots and nurseries near water points as income-generating activities for schools. The money raised is used to buy educational materials. These activities have been successful, although in very limited areas. Support to these activities will continue, but with strengthened community participation.

Education

9. The education programme was formulated primarily to support the health sector and, consequently, major activities in education included health education for primary schools, day-care and preschools and female literacy activities. The mid-term review recommended that education activities go beyond support to health because education is the key to sustainability of all development actions and because of the renewed thrust in education launched by the World Conference on Education for All. In addition to the programme for

health education, UNICEF resources will be focused on advocacy and innovative strategies that could lead to greater collaboration with multilateral and bilateral donors in the education sector.

Women

10. Gender-related issues cut across all UNICEF programmes. Health programmes aim to reduce maternal mortality and morbidity through actions such as tetanus toxoid vaccination of women of child-bearing age, improvement of health services and of the skills of maternal and child health (MCH) workers, and the establishment of referral systems. In the water supply and sanitation sector, women participate in the identification of water points and in the repair and maintenance of water pumps. In the education sector, women are the principal target of literacy activities because of existing gender disparities and the link between female literacy and child morbidity and mortality. In the next country programme, actions on behalf of the girl child will receive sharper focus in all sectors, including education and children in especially difficult circumstances.

## II. BOTSWANA

11. The country programme for Botswana was approved by the Executive Board in 1990 for the period 1990-1994 with available general resources of $7,683,000 (E/ICEF/1990/P/L.2). The annual planning level for Botswana was increased from $500,000 to $750,000 in 1991 and to $1 million in 1992 in order to accelerate activities within the framework of the country programme. Furthermore, because Botswana is a land-locked country, the country ceiling will be increased by 20 per cent starting in 1993. As a result, the balances of approved general resources are not sufficient to provide funding through the end of the approved country programme period. Therefore, an additional $2,105,000 is requested to replenish the approved amount of general resources.

Primary health care

12. Since the 1970s, the Government of Botswana has focused on the development of the country's health infrastructure to strengthen PHC delivery in order to reach certain targeted goals: (a) reduction of the infant mortality rate (IMR) to 37 per cent by 1995; (b) reduction of the maternal mortality rate (MMR) by 30 per cent by 1995; (c) maintaining prevalence of moderate malnutrition under 15 per cent and reducing severe malnutrition to less than 1 per cent; and (d) strengthening the decentralized PHC delivery system to ensure programme sustainability.

13. Botswana achieved UCI in 1988 through an immunization acceleration strategy that centred on the use of house-to-house coverage and channelling surveys in each district. By 1990, coverage for all childhood antigens had been achieved and coverage for two doses of tetanus toxoid vaccine reached 62 per cent. A policy-and-procedures manual has been produced with the support of UNICEF and the World Health Organization (WHO) to guide the delivery of the immunization programme. Plans for the eradication of polio have been completed. Vaccines and cold-chain equipment are now procured by the Government, with the exception of polio vaccine, which is provided by Rotary International. The project will

emphasize supervision of health workers and more post-training follow-up. The project will also strengthen the surveillance system and outbreak containment.

14. Diarrhoeal diseases remain a major cause of child morbidity. By 1990, 45 per cent of mothers were giving oral rehydration salts (ORS) to their children when they had diarrhoea. Some 85 per cent of the population has access to ORS since all health facilities stock it. More emphasis on community education will have a positive effect on improving knowledge and practices. In the next phase, more will be done at the community level in mobilizing teachers and village health centres to extend accessibility and partnership in diarrhoea management.

15. ARI are still the most common diagnosis made at health posts and represent 35 per cent of all diagnoses in all age groups and 43 per cent of all diagnoses in children under five years of age. Monitoring of ARI will be incorporated into the weekly monitoring reports. A baseline study undertaken in 1990 showed that village health workers (VHWs) still need more training on managing children with ARI. Community education will be stressed.

16. With regard to malaria control, guidelines on prevention have been produced with UNICEF support. A knowledge, attitude and practice survey has been implemented and will form the basis for a well-targeted community intervention programme. Malaria is a seasonal problem in Botswana. The objectives of the malaria control programme are to reduce malaria morbidity by 30 per cent and case fatality by 80 per cent by 1995.

17. The safe motherhood and perinatal health promotion project has been aimed at reducing transmission of the human immunodeficiency virus (HIV) and incidence of AIDS, advocating family planning, increasing the proportion of women attending antenatal care at least four times to 95 per cent, reducing the rate of teenage pregnancy to less that 15 per cent, reducing the rate of low birth weight to less than 15 per cent and reducing perinatal mortality by 20 per cent. This will be achieved through information and social mobilization to promote safe motherhood and increased in-service health worker training to ensure improved risk-factor screening. As MMR remains at around 200 per 100,000 live births, more IEC work will be emphasized to empower mothers and youth to deal with these problems.

18. The main challenges in the health sector lie in maintaining the gains made in the immunization project, strengthening control of ARI and diarrhoeal diseases, addressing the disparity between child and maternal health, improving district-level monitoring of goals and of management of the programme, and capacity-building through basic and in-service training. Overshadowing these activities, however, is the spectre of AIDS. The number of HIV-positive cases is rapidly increasing, with women of child-bearing age hit hardest. Teenage pregnancies also continue to rise and no progress has been made in reducing MMR. New goal-directed initiatives are under way to respond to these problems, along with a higher level of advocacy and education activities.

Education for All

19. This programme is designed to address qualitative problems associated with the expansion of the system in three substantive areas: (a) care and education

of the young child; (b) formal basic education; and (c) non-formal education. The particular groups of concern are young children between two and six years of age, children within the school system, children during the first nine years of education and children and adults outside the system.

20. The goal of the programme is to contribute to the emergence of a learning society in which care and education of the young child, a universal basic education of nine years or an equivalent out-of-school education will be the basis for life-long learning and self-sustaining individual and societal development.

21. The overall progress towards universal primary education in Botswana has been obvious. It is currently estimated that over 90 per cent of eligible children have access to primary education. Future activities will be targeted to identify the missing 10 per cent, bring them into schools and ensure that almost all of them complete the primary level.

22. To date, the limited available resources have been used to support training at all levels (trainers, supervisors, curriculum developers, attendants) in the basics of child development theory; the development of materials related to child survival, development and protection themes; training of literacy assistants; and social mobilization in all target areas.

Household food and economic security

23. This programme builds upon the solid base of drought management experiences and signals a qualitative change in the programme of cooperation to support efforts to tackle the significant structural poverty that exists in the country. With the rapid development of the mining sector in Botswana soon after independence, the country registered an impressive overall economic growth. The Government subsequently made massive investments to develop service and communications infrastructures in both rural and urban areas. However, the means of livelihood for the vast majority of the population are still underdeveloped. The mass of the rural population, who make up 78 per cent of the total, are poor. An estimated 63 per cent of Botswana households have an income level below what is necessary for meeting essential needs. The majority of households are extremely vulnerable to the effects of crises, as seen during the last drought, when a full 32 per cent of the population (excluding schoolchildren) were receiving food rations. The country is again in a drought situation.

24. The main goal of this programme is to improve household food and income security, with a special focus on ensuring access to and control of resources for the most vulnerable households.

25. There are three main components: (a) improvement of the database and monitoring systems to facilitate policy improvements; (b) strengthening institutional capacity at national, district and community levels; and (c) technology and production innovation to enhance food production and income generation. Pilot activities have begun in one district in the areas of employment and income generation for vulnerable households.

## III. EGYPT

26. The country programme for Egypt for the period 1990-1994 was approved by the Executive Board in 1989 with available general resources of $17 million (E/ICEF/1989/P/L.19). In 1992, the annual planning ceiling was raised to $4,950,000. This will result in the utilization of approved funds by early 1994. The present submission covers funds required for the remaining period of 1994 to continue implementation of the country programme approved by the Board in 1989.

27. Egypt receives a level of foreign aid considered among the highest in the world. In addition, donors recently wrote off a sizable portion of the national debt. Egypt has been undergoing economic reform, starting with the implementation of the Structural Adjustment Programme in 1990. To help reduce the impact on vulnerable groups, the Government created the Social Fund for Development, which gives priority to addressing unemployment and alleviating poverty. These developments were among the factors behind the overall improvement in the economic situation. However, disparities persist between Upper and Lower Egypt and between urban and rural areas, with pockets of poverty and destitution.

28. Egypt was one of the six countries that led preparations for the World Summit for Children and was one of the first countries to sign the Summit Declaration and ratify the Convention on the Rights of the Child. In July 1992, its NPA was completed under the guidance of the First Lady and incorporated as a separate chapter in the National Development Plan. Political leadership at various levels has shown strong support for children and women.

29. The country is facing a serious challenge because of demographic developments. The annual population growth rate is estimated at 2.8 per cent and the urban population will soon become larger than the rural population. As a result, the improvement and extension of services cannot keep pace with the population's growth and movement.

30. Egypt's health situation has improved markedly. IMR has dropped to 62 per 1,000 live births in 1991. Most of the gains can be attributed to high immunization coverage rates against vaccine-preventable diseases and the wide utilization of ORT for diarrhoea. As a result, ARI have replaced diarrhoeal diseases as the leading cause of infant and child mortality. Egypt has recently witnessed a drop in its ORT use rate.

31. Malnutrition remains a common problem among children in Egypt. Low birth weight is estimated to affect 10 per cent of newborns. After an early faltering up to six months of age, children appeared to grow at a normal rate for their reduced height and had reasonably normal weights for their height. However, those children never reached reference heights in subsequent years.

32. Maternal mortality remains the primary cause of death among women of child-bearing age and MMR is 320 per 100,000 live births. Around 25 per cent of pregnant or lactating women are anaemic. Recent anthropological studies showed that giving priority to daily chores prevented women from seeking preventive and curative care in nearby health units.

33. Water supply and sanitation services have increased but are still barely sufficient to cope with the population increase. The number of unserved people thus remains virtually unchanged. In Upper Egypt, only 30 per cent of the population have access to safe drinking water and 10 per cent to sustained sanitary waste disposal.

34. Despite the substantial increase in the number of classrooms and schools, the educational system remains overcrowded, with the schools suffering from a shortage of well-trained teachers and inappropriate school curricula. According to national statistics, 93 per cent of boys and 83 per cent of girls attended primary school in 1990. These figures hide problems of quality of instruction and drop-outs, particularly among girls. Literacy remains low, with female literacy averaging 34 per cent. Female literacy is lowest in Upper Egypt.

35. Egypt has a broad and extensive network of social services, as well as a large, educated human-resource base upon which to draw. However, those facilities tend to be distributed unevenly and are clustered largely in major urban areas. Consequently, services often fail to reach below the village level, leaving hamlets and satellite villages largely unserved. The population increase has made it more difficult to cope with their needs.

36. The television network reaches all regions of the country. More than 70 per cent of the people watch television daily. There are 12 daily and weekly newspapers with a total circulation of over 8 million. Egyptian radio has a large radius, covering all Arab countries and many countries of Africa.

37. The mid-term review of the country programme held in May 1992 was opened by the First Lady. Several government ministers and representatives of United Nations agencies, international and local non-governmental organizations (NGOs) and donors took part. The review highlighted the need (a) to retain the basic structure and priorities of the programme; (b) to consolidate successes in EPI and ORT to ensure sustainability; (c) based on the results of the evaluation, to revise the approach to water supply from an engineering-oriented to a community-based approach to ensure community ownership and affect both overall health and workloads; (d) to explore innovative approaches to basic education and area-based work on community development; (e) to ensure progress in the quantity and quality of services; and (f) to improve the use of information for advocacy, mobilization and for developing family knowledge and skills.

38. The 1990-1994 programme reflects the social priorities of the National Development Plan (1993-1997) and falls in line with the goals and directions of the NPA. The major objectives are: (a) to maintain the child on the political agenda; (b) to halve IMR to less than 50 per 1,000 live births by 1994; (c) to halve MMR to less than 160 per 100,000 live births by 1994 in Upper Egypt; and (d) to raise the quality of life of children and women. Specific objectives include: (a) the eradication of polio; (b) the virtual elimination of neonatal deaths; (c) the reduction in measles deaths by 95 per cent; (d) an increase in girls' enrolment and retention in schools; (e) the empowerment of families with the facts, knowledge and information required for the protection and development of their children; (f) the improvement of the capacity of governmental and non-governmental services to advocate, deliver and sustain services to benefit children; and (g) the involvement of communities in the planning, operation and maintenance of area-based services.

Health services

39. The health programme consists of components for EPI, CDD, ARI, safe motherhood and nutrition. It will aim at consolidating gains in EPI and CDD through increasing and maintaining vaccination coverage and re-establishing the high ORT use rate of 80 per cent. Egypt and Morocco were selected as flagship countries for accelerated CDD. Increased financial self-reliance will be promoted and the development of health cost-recovery at the community level will be made. The safe motherhood project will promote awareness of traditional birth attendants (TBAs) and mothers regarding safe delivery practices. Initial work in the "baby-friendly" hospital initiative will go to scale. The focus on nutrition will encompass promoting national goals and tailoring the International Nutrition Programme, adopted by the recent International Conference on Nutrition and supported by WHO and the Food and Agriculture Organization of the United Nations (FAO), to the conditions and needs of Egypt.

40. UNICEF will continue to support the development of local vaccine production and distribution capacities, improvement of the cold chain, retraining of health care providers and new medical graduates and strengthening of supervision and communication. Support will continue to be given to social mobilization and advocacy involving the informal health sector and the non-health sectors. UNICEF will also support disease surveillance and evaluation to gauge project implementation and to assess the impact of projects on mortality and morbidity.

Water supply and sanitation

41. On the basis of the experience gained and the results of the external assessment of rural water supply, the focus of the programme will shift to a more community-based approach. Limited experimentation has shown that performance improved significantly, bringing the rate of accessibility to 80 per cent. Other elements are also included, such as the use of appropriate technology, the involvement of the community in operation and maintenance and the promotion of health education, sanitation and environmental protection.

Education

42. The World Conference on Education For All has resulted in increased importance being given to education. UNICEF, together with the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNDP and the World Bank, gave priority to promoting the Education for All Plan of Action. In selecting Egypt as the flagship country of the Middle East and North Africa for education, UNICEF will focus on innovative approaches for increasing girls' enrolment and retention in schools and for promoting female literacy. Positive beginnings will be replicated through community schools that combine community involvement with emphasis on basic learning skills and life-oriented knowledge. The development of an information base, particularly at the local level, will help in monitoring progress and maintaining community interest in girls' education. Television spots addressing girls, parents, teachers and policy makers will be developed to raise awareness at the national level.

Women's development

43. This programme originally aimed to improve the quality of life of poor, rural female-headed households by improving their income levels and through better use of services, such as loans for income-generating activities and day-care services for preschool children. The village bank would provide female heads of households with loans to be used for small livestock, food processing and drying, sewing, handicrafts and other small projects. As a result of the mid-term review, which found that the programme was too confined to traditional women's activities, the strategy will be broadened. UNICEF will support the development and promotion of an action-oriented national policy for the empowerment of women through greater participation in national and local development processes. The management of this programme will be decentralized to ensure closer linkage with NGOs. Innovative approaches to facilitate access by poor women to credit by establishing partnerships with NGOs and a development bank along the lines of the Grameen Bank in Bangladesh will be supported. The economic dimension of the programme will serve as an entry point for community development activities for the rural and urban poor of Upper Egypt, Cairo and Alexandria.

Communication and advocacy

44. Capacity-building to help radio and television serve social goals more effectively will continue as a priority activity. The training of IEC personnel at the Health Ministry and mass communications departments at selected universities will be pursued to improve their capacities for planning and managing programmes affecting child survival, protection and development. UNICEF will support action-oriented workshops and experience exchange activities, leading to concrete action. Priority will be given for producing communication materials to help sustain ongoing programmes and the increased awareness of the Convention on the Rights of the Child. The main categories of sectoral information include safe motherhood and birth spacing; breast-feeding, "baby-friendly" hospitals and child feeding; immunization; diarrhoea prevention and control; detection and treatment of ARI; and home hygiene.

Area-based community development

45. Based on the results of the mid-term review, there will be increased emphasis at the community level on giving communities a greater role in decision-making. As a translation of government policy for increasing community involvement in the development process, a strategy will be developed with UNICEF support to address the concerns and needs of the rural and urban poor. UNICEF will support policy formulation; experimentation with innovative, community-based approaches in urban and rural areas; and development of action programmes. Activities will include better use of existing institutions and resources; capacity-building, including NGOs; and integrating the programme components being implemented nationwide for higher coverage, greater impact and ownership by the community.

Child monitoring and evaluation

46. UNICEF will continue to support the collection, analysis and dissemination of reliable information about the situation of children and women. To this end,

both the Central Agency for Public Mobilization and Statistics and the National Council for Childhood and Motherhood will continue to receive support for their activities on data collection and monitoring.

47. Collaboration with universities and research institutions will facilitate economic analysis of programmes and formulation of cost-recovery policies. Studies will include protecting vulnerable groups from the results of structural adjustment policies and developing a system for monitoring the social situation at local and national levels. Special attention will be given to monitoring progress towards reaching the NPA goals and compliance with the provisions of the Convention on the Rights of the Child.

Cooperation with other United Nations and bilateral organizations

48. Close collaboration will continue to be maintained with concerned United Nations organizations. Collaboration with UNDP, particularly in linking the human development profile with the NPA, which later expanded to include the members of the Joint Consultative Group on Policy, WHO and UNESCO, will continue. This collaborative effort has already started in Assiut Governorate.

49. A new partnership has recently emerged among UNDP, the Government Social Fund for Development and UNICEF. With UNDP focusing on the economic and infrastructure components, UNICEF was requested to provide technical support to the social and community development aspects of the work of the Fund.

## IV. MALDIVES

50. The country programme for Maldives for the period 1990-1994 was approved by the Executive Board in 1990 with an allocation of $1,500,000 from general resources (E/ICEF/1990/P/L.26). Because of the increased availability of general resources, the Executive Board approved additional general resources of $916,000 in 1992 for the period 1992-1993. An additional allocation of $430,000 is now requested to fund the approved programme until a new programme is presented to the Board in 1994.

51. The primary focus of the current programme of cooperation is a package of services for child survival and development (CSD). Within this framework, and with the adjustment necessary for the achievement of the goals for the 1990s set by the Government in the NPA for children as a follow-up to the World Summit for Children, funds will be used to carry out activities in the following major programme areas in 1994.

Health and nutrition

52. Since the achievement of UCI in 1989, Maldives has increased immunization coverage to above 90 per cent. Efforts will be made to sustain that coverage, as well as to eliminate neonatal tetanus by 1995, maintain the current zero polio status and eradicate polio by the year 2000. Interventions in the area of CDD, which have already helped to reduce the number of diarrhoea-related child deaths, will be continued. Activities will include the promotion of appropriate home management techniques such as the use of ORT, continued feeding and hygiene education.

53. Although IMR in Maldives dropped from 95 per 1,000 live births in 1980 to 34 per 1,000 live births in 1990, as reported by the Ministry of Health, MMR remains as high as 300 per 100,000 live births. Poor delivery conditions in the islands and the fact that some 50 per cent of all deliveries are handled by untrained TBAs contribute to the high MMR. The issue will be addressed through the improvement of antenatal and postnatal care at the island level, TBA training to provide safe delivery services and the strengthening of referral services. Support will also be provided for advocacy and education about the appropriate age for marriage and child spacing.

54. Since ARI are the leading causes of death in children under five years of age, a programme to combat these disorders will be implemented in collaboration with WHO. Its major thrust will be training family health workers in the diagnosis and case management of ARI.

55. The growth monitoring project, presently covering about 80 per cent of the children under three years of age, will be continued to increase coverage to 90 per cent, with an emphasis on advising mothers of children whose growth is faltering. Activities will include workshops for health workers to promote growth monitoring and nutrition education, and awareness-creation activities involving island women's committees.

Water supply and sanitation

56. The construction of rainwater tanks for communities and households will be continued. A new design for sanitary latrines is being tested and, if found acceptable, it will be used for the promotion of latrine construction. Support will also be provided for community and school education, focusing on the preservation and protection of water, personal hygiene and the safe disposal of human waste and garbage. The training of island masons will be continued.

Education

57. Maldives has achieved high literacy and primary school enrolment rates, with little gender discrimination. The quality of education and school completion rates are areas of concern, however. High priority will be given to the teacher-training programme, and condensed education courses linked to skills development will be organized for school drop-outs, with preference given to adolescent girls. Distance education programmes will be continued, as the country is composed of widely dispersed islands.

Women in development

58. Support will focus on island-based women's centres, which are the basis for the social organization of women on the islands. Each centre has one or two rooms provided by the island and furnished by various government sectors. One room of the centre, staffed by a family health worker and a trained TBA, will serve as a delivery room to provide MCH services. The other room will be used for meetings, training, demonstrations and reading. Activities leading to the improvement of the physical environment of children and women and the reduction of their workload will also be undertaken. Communication efforts will focus on the appropriate age for marriage, child spacing and the need for extra food for adolescent girls and pregnant and lactating mothers.

## V. THE NIGER

59. The country programme for the Niger for the period 1990-1994 was approved by the Executive Board in 1989 with an allocation of $7,500,000 from general resources (E/ICEF/1989/P/L.7). The annual planning level was increased to $1,900,000 in 1990, and then again to $2,180,000 in 1991, with a view to accelerating activities within the framework of the programme. In order to reflect these approved increases and to ensure the provision of additional resources, additional funding of $2,695,000 from general resources is requested for the period 1993-1994. A new country programme recommendation will be submitted to the Executive Board in 1994.

60. Since the new country programme was launched in 1990, the economic and social situation in the Niger has continued to deteriorate rapidly. This has substantially reduced the options available to the new transitional Government responsible for laying the groundwork for the third republic. A series of strikes and demonstrations, organized, in most cases, by the opposition, has led to rioting. This already explosive social situation has been further complicated by the Touareg rebellion in the northern part of the country. The gross national product, estimated at $300 per capita in 1991, conceals vast disparities. The indicators relating to child survival and development clearly demonstrate the vulnerability of women and children in the Niger and the precariousness of their situation, especially in the areas considered to be difficult to access. The child and infant-child mortality rates of 127 and 218 per 1,000 live births, respectively, remain very high.

61. Despite some progress, the execution of the current country programme has been slowed down by political instability, five successive Governments having taken office between January 1990 and December 1992. These frequent political upheavals, and the ensuing paralysis of the administrative machinery, have had undeniable consequences for the implementation and follow-up of programmes and projects. However, the first democratic elections in the Niger, to be held very shortly, herald a period of calm conducive to the implementation of the recommendations made during the technical review, which was conducted in February 1992, in close collaboration with headquarters and the regional office.

Health

62. Owing to financial difficulties, the transitional Government of the Niger has adopted a health strategy based on decentralization and community participation, as proposed by the Bamako Initiative. Since 1990, this has involved strengthening the methods of planning, programming and managing the health activities undertaken during the 1985-1989 cycle, and improving health-care services through the development of preventive activities (the expanded programme on immunization (EPI), prenatal and child care, the control of malaria and diarrhoeal diseases, etc.). UNICEF will continue to strengthen the health-care system by: (a) helping to bring health-care centres as close as possible to users; (b) supporting the development of a cost-recovery system and the introduction of a system whereby patients will share health costs; and (c) helping to rationalize the use of basic medications, including the traditional pharmacopoeia. The decentralization measures envisaged should promote the implementation of these strategies in a significant manner, while making possible the development of departmental action plans which can take into

account, in the definition of aims, strategies and activities relating to primary health care (PHC), the constraints specific to each sector. Through the enhancement of microplanning, UNICEF will assist health-care organizations and personnel in the development of annual action plans designed to accelerate the expansion of PHC.

Nutrition and food security

63. The food-production sector, which is basic to the economy of the Niger, with nearly 85 per cent of the population engaged in agriculture and animal-raising, is geared mainly to meeting international needs. After achieving a surplus in the 1960s, the country has been subject in recent years to a chronic shortage of cereal grains, which has a direct impact on the nutritional status of young children. The UNICEF programme is perfectly suited to the framework adopted by the Niger and is based on the experience gained through the implementation of the joint nutrition support programme. This programme serves as a frame of reference for the establishment of a dynamic leading to the eradication of malnutrition at the family and community levels. In order to achieve this aim, communities are being trained in the use of the "three-A" method (assessment, analysis and action) and in the promotion of child growth. The programme then supports the activities undertaken by the communities. Thus, in 1992, the programme supported the development of 625 hectares of dry-season crops and 6,500 hectares of rainy-season crops, with related activities, such as the establishment of cereal-grain banks, the installation of millet mills, the promotion of adult literacy and the operation of radio clubs. In 1993 and 1994, the same programme strategy will be pursued; it will be consolidated in the 111 villages which it is designed to cover, and will be expanded to 65 new villages, with priority placed on: (a) giving women total responsibility for all the activities undertaken; (b) limiting such activities, in the field of food production, to those which promise to have a lasting impact; (c) promoting nutritional education in direct relationship to the promotion of growth; and (d) introducing and developing a formal system of ongoing programme follow-up and evaluation.

Water supply and sanitation

64. Since 1970, Niger, which is to a great extent subject to an unpredictable climate, in particular drought, has been largely dependent on underground water to meet its basic water supply needs. The country endorsed the Mar del Plata Plan of Action and has made a commitment to supply drinking water to the entire population. The Niger's formal commitment to meet the population's drinking water needs has thus led to the creation of 9,300 modern water points during the International Drinking Water Supply and Sanitation Decade, bringing the rate of theoretical coverage to 64 per cent, the real rate being approximately 50 per cent, given the high number of wells which are not functioning owing to frequent breakdowns of hand-pumps. The needs are even more urgent in the hygiene and sanitation sub-sector which, outside urban areas, has benefited from only a very few activities which are too often limited to developing community leadership. In this regard, UNICEF is working to consolidate all the investments provided to the Ziner département since 1985 and to develop its role in the Maradi département, which has one of the lowest rates of water coverage in the country (less than 50 per cent). To this end, the strategy of reference focuses on making beneficiaries fully responsible, through their physical and

financial commitment, and on the use of the modern water point as a starting-point for the integrated development of the community. The continuity of these activities is ensured by a non-governmental organization, the Brigade de Mayahi. Lastly, since 1992, the programme has made the elimination of dracunculiasis a priority.

Education

65. In accordance with the recommendations of the World Conference on Education for All and the continuing restructuring of educational programmes which began in 1990, in 1992 the UNICEF-supported programme gave priority to women's literacy and training, to improving the school attendance of girls and to the situation of children in especially difficult circumstances. In the area of primary education, particular attention was given to educating the girl child. Support for the "school garden" project as a way of improving the diet and nutrition of schoolchildren has made it possible to create 40 school cooperatives and to supply 150, or 60 per cent, of the school cafeterias. A current study of children in especially difficult circumstances should help to improve the orientation and focus of UNICEF support in this area of activity. UNICEF has also supported the opening of training centres for 50 child guides for the blind in two poor neighbourhoods in Niamey. In 1993 and 1994, the same programme strategy will be pursued with a view to extending it to the non-formal sector. The education of parents and collaboration with the communities will be improved, in accordance with the recommendations of the workshop on "The Young Child in the Sahelian Environment", held in Niamey from 24 to 31 August 1992, with a special focus on (a) the experience of non-formal education and the education of communities and parents; (b) the care of preschool children in rural areas; and (c) the promotion of school attendance by girls.

Women and development

66. UNICEF, which is aware of the role of women in society, will continue to support programmes aimed at improving their condition at the national level and at the community level, to endeavour to influence decisions regarding women and to include the particular aspirations and needs of women in the development process. UNICEF, like many of the Niger's partners, is assisting the transitional Government in its efforts to improve the situation of women throughout the country. A principal activity has been advocacy and institutional support at the highest level, which has resulted in the finalization of the Family Code. As far as current programmes are concerned, the component relating to women is taken into consideration in all sectors. UNICEF will continue to promote and develop strategies aimed at the full participation of women and at increasing their responsibility with regard to: (a) the development of their abilities through training and consciousness-raising; and (b) the improvement of their incomes and reduction of their workloads. Women in village communities will be introduced to the "three-A" method (assessment, analysis and action) so that they may be more in control of their problems. UNICEF will strengthen its support for specific projects involving safe motherhood, as well as its support for the National Committee to combat harmful traditional practices.

Social mobilization

67. This programme provided for the use of development structures such as village development councils, l'Association des Femmes du Niger and Samariya (youth association) in addition to the use of traditional and modern media to bring about a change in the behaviour of the population that would promote the well-being of women and children. UNICEF works with the modern media and, in particular, with radio clubs. It must be noted, however, that questions arose about all of these development structures during the national Conference. Accordingly, a reorientation of the information and communication strategy has proved necessary. In order to improve the population's access to radio news broadcasts, strengthen the mass media infrastructure and assist in decentralization, UNICEF will continue to emphasize the development of strategies that focus on women both as the principal beneficiaries of social mobilization activities and as the principal players in efforts to promote the survival and development of young children. In this context, priority will be given to providing the population with the know-how to prepare consciousness-raising messages and action will be taken at the village level, the most operational level to facilitate the introduction of participation techniques.

Monitoring and evaluation

68. Unsystematic monitoring and evaluation based on surveys and periodic evaluations of various programmes have impeded the monitoring of the execution and impact of programmed activities. Following the technical review, it was decided that an operational monitoring system should be set up to document, through the continual collection of data, the impact of operations carried out and their impact on the programme goals in each of the sectors studied. To this end, UNICEF will increase its assistance in order to permit the introduction of an evaluation process based on the "sentinel site" approach, particularly in the integrated programme of basic services in Aguié and the nutrition and food security programme.

## VI. PHILIPPINES

69. The current bridging programme for the Philippines was approved by the Executive Board in 1991 for the period 1991-1993 with an allocation of $12,300,000 from general resources, extending the five-year programme cycle (1988-1992) to 1993 (E/ICEF/1991/P/L.15). Because of the increased availability of general resources and a high implementation rate, the 1992 planning level for the Philippines was increased from $4,100,000 to $5,160,000 to accelerate some priority activities such as the elimination of iodine deficiency disorders (IDD), the promotion of the "baby-friendly" hospital initiative and EPI.

70. The primary focus in 1993 is on the completion of the activities planned for the current cycle and preparations for the new country programme for the period 1994-1998. Efforts will be made to consolidate the achievements of the past two years in adjusting ongoing programmes to fit in the broader framework of the Philippine Plan of Action for Children launched by the President in December 1991, in response to the World Summit for Children.

Health

71. The programme will continue to sustain the coverage of UCI at 85 per cent and to increase the coverage of tetanus toxoid immunization among pregnant women from 52 per cent in 1991 to 80 per cent by 1993. Special vaccination strategies such as "mop-up" campaigns and outreach services will be used in addition to regular services for far-flung or hard-to-reach areas. National immunization days, a strategy for the eradication of polio in the Philippines, will be started in early 1993. UNICEF will assist in organizing these activities through area conferences and increasing the capabilities of health personnel for EPI disease surveillance. A packaged approach based on the "EPI Plus" concept will be initiated in 1993, including vitamin A distribution, growth monitoring and promotion and prevention of anaemia.

72. The project for control of ARI will expand the number of trained health centre personnel and increase coverage through standard ARI case management. The training of community health workers will be expanded to help them act as communicators concerning ARI by identifying and referring pneumonia cases and dispensing initial drug therapy for children. IEC materials will be developed for interpersonal counselling between health workers and mothers of children under five years of age, based on ethnographic studies and ARI household surveys.

73. An operations manual concerning care for mothers and children under five years of age will be developed and produced. This will provide local government units with guidelines on MCH standards. The revised "Home-based Mother's Record" will be reproduced and used nationwide, involving rural health midwives, public health nurses, rural health physicians and VHWs.

Nutrition

74. Continued support will be given to breast-feeding promotion by building on the success of the "baby-friendly" hospital initiative in 1992. The training capacity of the 14 regional lactation management hospitals will be strengthened to support provincial and district hospitals in promoting the "10 steps to successful breast-feeding". Midwives will be provided with training for counselling mothers in lactation management.

75. The programme will continue to promote ORT to prevent and treat dehydration at home and health centres. Training will continue in diarrhoea case management for health workers. Mothers will be taught about home fluids and proper feeding during children's diarrhoeal episodes. Messages will be reinforced through media campaigns and IEC activities.

76. The project for growth monitoring and promotion for infants will begin to be integrated into EPI Plus activities. In selected provinces, growth promotion among children aged 13 to 59 months will be reinforced with health and nutrition counselling services for mothers, and local village councils will be involved in the assessment of nutritional status of children. Family food production activities in six provinces will be strengthened with the revival of organizations of mothers, formerly known as Rural Improvement Clubs, to promote the production and preparation of nutritious foods for children.

77. The project on micronutrient malnutrition includes iodine supplementation for women of child-bearing age in endemic areas; provision of iron foliate supplements to pregnant and lactating mothers; and distribution of vitamin A capsules for infants and lactating mothers. An operational plan will be developed for the nationwide elimination of IDD.

Water supply and sanitation

78. This programme will focus on advocacy for proper utilization of water supply and sanitation facilities and improved hygiene practices. National advocacy aims to improve sectoral policies on the use of water supply and sanitation facilities, the development of IEC and training materials for communities and the installation of a monitoring system. Community-based project models will be developed and demonstrated to influence policy makers at national and local levels to promote environmentally friendly, appropriate technologies.

Education

79. Functional literacy remains at 73 per cent, leaving 12 million persons functionally illiterate, many of whom are women in Muslim Mindanao. About 35 per cent of all primary schools in less populated and isolated areas do not offer sixth grade, an indication of the need for more multi-grade classes. In 1993, the programme will focus on expansion of early childhood care and development to improve the readiness of children for school; improvement of multi-grade teaching; expansion of female functional literacy; and testing of alternative learning systems for cultural communities and children in especially difficult circumstances.

Women in development

80. The programme will continue to address the twin issues of women's multiple burdens and the lack of appropriate support programmes for women and adolescent girls in disadvantaged situations. The Inter-Agency Committee for the Enhancement of the Role and Status for Filipina Women in Social Development will coordinate advocacy with all sectoral programmes designed for women. The recently completed gender-sensitive framework for women in development spells out major considerations in planning and programming development projects for women. Savings and credit schemes will continue to be implemented in six of the most depressed provinces.

Area-based child survival and development programme

81. The programme has demonstrated the feasibility of local government delivery of basic services to disadvantaged children, women, families and communities. This was borne out by a major study by the University of the Philippines on the institutionalization of area-based CSD programmes. The second and third phases of the study in 1993 will entail the preparation of strategies, an operations manual and a training package to build the capability of local government units to achieve the goals of the Philippine Plan of Action for Children by the year 2000.

82. Special attention will be given to improving the convergent delivery of services to high-risk groups; refining a community-based child monitoring system; further involving Islamic leaders in promoting child survival, development and protection; and fully integrating the area-based CSD programmes in the development plans of the seven provinces selected for sustainability beyond 1993.

Urban basic services programme

83. Efforts will be made to expand coverage so that the urban basic services (UBS) programme contributes to the achievement of national goals. The year 1993 provides a bridge towards the "metropolitan approach" (covering three major metropolitan areas and six other major cities).

84. Priority activities include: (a) sustained UCI and EPI Plus including ARI, CDD and the "baby-friendly" hospital initiative; (b) prevention of dengue fever in urban slums and squatter communities, linked with community-based, environmentally friendly sanitation initiatives; (c) HIV/AIDS prevention in major cities; (d) acceleration of family and community education and preventive services for street children; (e) child and maternal nutrition, including growth monitoring and promotion, micronutrient supplementation and family food production; and (f) sustaining gains in community participation and empowerment. As the UBS strategy is a major element in the Government's Pro-Poor Programmes, an assessment of these experiences will draw lessons for going to scale and thus contribute to the Government's poverty alleviation efforts.

Children in especially difficult circumstances

85. The child labour project will intensify advocacy and social mobilization to increase the involvement of local government units in educating parents and all concerned sectors on the rights of working children, as well as promoting their rights and development. It is expected that local government units will allocate more funds and other resources for working children. A major activity is to reduce the number of children working in hazardous employment, through community organization and parental education services linked with viable livelihood opportunities for parents.

86. The project for children in situations of armed conflict will continue to focus on efforts such as the provision of basic services, the protection and promotion of the rights of these children and resource mobilization. Approximately 48,000 children up to 17 years of age in 25 provinces will be provided with health care, nutrition, counselling and alternative education services. Service workers and parents of children in situations of armed conflict will be trained in disaster management and counselling. Local government unit employees will receive training to implement services for these children. Peace education for schoolchildren and education for the military and the police on the rights of the child will be expanded.

Social mobilization

87. The programme will sustain the current momentum for promoting the Convention on the Rights of the Child and implementation of the Philippine Plan of Action for Children at sub-national levels. These efforts will expand and

institutionalize alliances with NGOs, the media and religious and special groups such as lawyers and health professionals. Emphasis will be placed on advocacy for resource mobilization among local government units and on the private and business sectors. Priority will also be given to increasing community access to knowledge in the area of health services for children, using Facts for Life.

Child monitoring

88. The programme aims to establish a more comprehensive database on children and to develop the capacity of local governments to prepare, implement and monitor plans of action for children. The focus is on monitoring the national plan and on activities to enhance a system for child monitoring. Monitoring the national plan includes an annual implementation report on goal achievement, sub-national government preparation of plans of action and measurement of indicators. The child monitoring system will be enriched by the 1993 National Health Survey and by an analysis of lessons learned from the testing of the community-based child monitoring system in selected municipalities in area-based CSD programmes.

## VII. SYRIAN ARAB REPUBLIC

89. The country programme for the Syrian Arab Republic for the period 1991-1995 was approved by the Executive Board in 1990 with available general resources of $2.5 million. Because the annual planning level was raised to $1 million as of 1992, approved funds will be utilized by the end of 1993. The present submission is for funds required in 1994 and 1995 to continue the implementation of the country programme approved by the Board in 1990.

90. The economy improved in the early 1990s in comparison with the difficulties faced in the preceding decade. Prevailing problems such as weaknesses in management, low productivity, idle capacity and underemployment in the public sector continue to cloud the country's long-term economic outlook. In addition, rapid population growth (3.6 per cent per year), accompanied by a high rate of rural-urban migration, is adversely affecting agricultural production, overburdening basic services in urban centres and leading to the growth of uncontrolled squatter areas around the edges of major cities.

91. Government emphasis on social development is reflected in its continuing support to education and health services and regional development. However, the quality of social services remains a major concern. In the health sector, staffing of primary-level health services is biased in favour of urban centres. Shortages of means of transportation in rural areas limit outreach services. Inadequate staff training in the health and education sectors is a major problem in both rural and urban areas. The education sector suffers from an uneven distribution of institutions. The quality of education and learning material remains weak.

92. Results of the 1990 EPI/CDD/mortality survey carried out by the Ministry of Health, with support from UNICEF and WHO, indicated a drop in IMR and the under-five mortality rate (U5MR) to 33 and 44 per 1,000 live births, respectively. Available data also showed that 52 per cent of infant deaths occur in the first month of life. The main causes of such deaths are congenital anomalies,

premature births and other birth-related causes (72 per cent), followed by ARI (5 per cent) and diarrhoea (4 per cent). Causes of mortality in the first year are congenital problems, premature births and birth-related factors (49 per cent), followed by diarrhoea (20 per cent) and ARI (10 per cent). Overall, the rate of perinatal deaths in the country is 42.2 per 1,000 live births.

93. The 1990 maternal mortality survey estimated MMR in the Syrian Arab Republic at 143 per 100,000 live births. Recent Ministry of Health data indicated that 64 per cent of all deliveries occur at home. The 1990 survey found that in urban areas 42 per cent of deliveries were attended by physicians, while local dayas (TBAs) attended 29 per cent of deliveries in rural areas and 28 per cent were attended by midwives.

94. The 1991-1995 programme of cooperation largely reflects the priorities of the NPA. The main objectives are: (a) to maintain priority status of the child on the national political agenda; (b) to reduce U5MR from 44 per 1,000 live births in 1990 to 36 in 1995; (c) to reduce MMR from 143 per 100,000 live births in 1990 to 80 by 1995; and (d) to reduce the primary school drop-out rate from 17 per cent in 1990 to 12 per cent in 1995.

95. Programme-specific objectives are: (a) to eradicate polio; (b) to eliminate neonatal tetanus; (c) to reduce measles deaths by 90 per cent; (d) to strengthen MCH services and promote better maternal and infant feeding practices; (e) to increase female literacy rates; and (f) to empower women with knowledge and information required to protect the lives of their children. The funds requested will be used in 1994 and 1995 to continue activities in the following programme areas.

Health

96. The Government has made extensive efforts to accelerate immunization in all governorates in order to achieve the goals of eradicating polio and reducing measles mortality by 90 per cent by 1995. The 1992 EPI review showed that immunization coverage for children up to one year of age has been sustained. Specifically, coverage reached 93 per cent for tuberculosis and 90 per cent for diphtheria, pertussis, tetanus, polio and measles. In the area of CDD, the Ministry of Health has been giving great importance to training health and non-health staff, increasing awareness of prevention and home management and to community education. None the less, meagre water supplies and poor sanitation facilities continue as a persistent factor in causing high diarrhoea incidence. The ARI control programme initiated in a few major governorates in 1991 will be extended to the remaining governorates. The TBA training programme will be expanded into a maternal health programme that will address the problem of high maternal mortality. This includes increasing prenatal and postnatal care coverage and deliveries by a trained attendant to 90 per cent of pregnant women. These activities will be developed further and implemented in close collaboration with WHO.

97. UNICEF will continue to provide a part of vaccine requirements, particularly of polio vaccine, to help meet the goal of eradicating polio by 1995. Support will also be given to improvement of the reporting and surveillance system. UNICEF will continue to support efforts to achieve

80 per cent use of ORT (home fluids or ORS) and to prevent diarrhoeal dehydration among children under five years of age. Training of health and non-health personnel will remain a key component of UNICEF support to health projects including EPI, CDD, ARI and safe motherhood, with the aim of improving the quality of services, especially at the peripheral level. Special efforts will be made in the areas of social mobilization and health education to increase community and family awareness of prevention and home management and to increase demand for services.

Nutrition

98. The promotion of breast-feeding and improved weaning practices will be major interventions to reduce malnutrition and diarrhoea-related mortality and morbidity. These activities will be coordinated by a newly established governmental national committee for the promotion of breast-feeding, comprised of all concerned governmental bodies and NGOs. The National Maternity Hospital was designated as "baby-friendly" in 1992, and it is planned that all other maternity hospitals will become "baby-friendly" by 1994. To assist in this task, UNICEF will support training of health staff, modification of medical school curricula, establishment of a national monitoring system and provision of equipment to health education units in maternity centres. UNICEF will also support government breast-feeding promotion campaigns.

99. The IDD project will be expanded using a twin approach: provision of iodized oil injections to children 7-12 years of age; and iodization and consumption of locally produced iodized salt by the population at large. UNICEF will continue to support the reduction of goitre rates in schoolchildren to less than 10 per cent by 1995 through the training of relevant staff, increasing public awareness and providing educational materials and other supplies and equipment.

Education

100. UNICEF assistance is directed at upgrading early childhood development and primary education, especially in rural areas; the reduction of gender disparity and promotion of girls' education; and improvement of women's literacy in the needy geographical areas. UNICEF and the Ministry of Education will work closely in the development of revised curricula and training and information materials to improve knowledge and practices of care givers and teachers on promoting optimal early childhood development. UNICEF will also support the Ministry in enhancing the relevance and quality of adult literacy programmes for women.

Advocacy and social mobilization

101. UNICEF will continue to support numerous social mobilization activities, strengthening the involvement of the Government, NGOs and the private sector in CSD efforts, as well as maintaining a high priority for children on the national agenda. The social mobilization programme will promote the use of Facts for Life messages and focus on the rights of the child and implementation of the NPA.

Monitoring and evaluation

102. In addition to ongoing monitoring and review activities, an annual in-depth programme review will be held every November/December under the chairmanship of the Syrian Planning Commission. A mid-term review will be held in late 1993 to pave the way for the formulation of a new programme of cooperation to be presented to the 1995 Executive Board. In addition, an evaluation will be conducted to gauge progress towards meeting the IDD goal.

Inter-agency cooperation

103. Close cooperation will be maintained with WHO in the development, implementation and review of the health and nutrition programmes. Collaboration will also continue with the United Nations Population Fund (UNFPA) in the implementation of the daya training programme.

## VIII. THAILAND

104. The current country programme for Thailand was approved by the Executive Board in 1989 for the period 1989-1993 with a total allocation of $12,500,000 from general resources (E/ICEF/1989/P/L.17). Due to a high implementation level and availability of additional general resources, the planning level was increased in 1992 and 1993 to accelerate ongoing programme activities, including the promotion of the "baby-friendly" hospital initiative. In order to maintain programme continuity and to fill the funding gap until the new country programme of cooperation is presented to the Executive Board in 1994, an additional amount of $1,500,000 from general resources is requested for 1993-1994.

105. Because of Thailand's CSD achievements and the emerging issues of children in especially difficult circumstances, AIDS, income disparities in urban and rural areas and environmental degradation, the primary focus of the programme is to help sustain the gains made so far in health and education; to reach hard-to-reach population groups; and to assist the Government in achieving its goals for the mid-1990s.

Health and nutrition

106. UCI was achieved in 1990 at the national level, and efforts will be continued towards achieving UCI at sub-national levels and sustaining child immunization at 90 per cent, including hard-to-reach children in remote areas. The Government aims to eradicate polio by 1996. CDD interventions will be continued and the acceleration of the control of ARI in all 72 provinces will be maintained. Although PHC extends to all areas of Thailand, particular attention will be paid to districts in remote areas so as to ensure effective participation in and delivery of health services.

107. Increased programme support has been provided to meet the Government's goals of reducing the prevalence of iodine deficiency, iron deficiency anaemia and vitamin A deficiency. Interventions to eliminate second- and third-degree malnutrition and to sustain growth monitoring will be maintained, while increased support will be given to the accelerated promotion of breast-feeding, in keeping with the priority placed upon this by the Government. Active

collaboration will continue in achieving nationwide accreditation of "baby-friendly" hospitals, to which the Ministry of Public Health has accorded very high priority.

Prevention and control of HIV/AIDS

108. Several innovative projects have been developed to prevent the spread of HIV and sexually transmitted diseases among young adults and minority populations. An awareness, education and counselling project was initiated in provinces in the north-east region, concentrating on young factory workers. Support was also provided to the Ministry of the Interior for HIV/AIDS education programmes in all municipal schools in Thailand. In addition to the Ministry of Public Health, programme and funding cooperation has been developed with other key ministries, the Bangkok Metropolitan Administration and major NGOs. It is expected that HIV/AIDS prevention activities will continue to be accelerated in the next programme cycle.

Water supply and sanitation

109. By 1992, 75 per cent of households had access to clean drinking water and latrines. Thailand expects to achieve universal water supply and sanitation coverage by 1996. UNICEF will continue to cooperate actively in the provision of funds for low-cost rainwater catchment jars; the installation of water-sealed household latrines; and the improvement of personal hygiene and home and food sanitation through education, primarily of women.

Early childhood development

110. The utilization of community and family resources in home-based early childhood stimulation programmes has been strengthened with increased government and NGO support. An innovative feature of the programme has been the specific focus on mothers who, following training, had access to resources for child development and support from government workers to enhance their role in early childhood development. The approach has been institutionalized by the Government for all early childhood development programmes. UNICEF support to early childhood development will be continued.

Basic education

111. The incorporation of development activities into the primary school curriculum has been reinforced through work-oriented education and the promotion of health-related activities. Active collaboration has also been developed in primary schools with regard to the improved nutritional status of schoolchildren and the control of IDD. Advocacy and technical support will continue for Thailand's initiatives on Education for All, including increased support for non-formal education.

Integrated basic services in deprived areas

112. An area-based programme begun in the 1989-1993 programme of cooperation has succeeded in meeting the basic minimum needs of deprived rural populations. The programme, involving close intersectoral collaboration, conforms closely to the

Government's development priorities for the most disadvantaged population groups.

Urban basic services

113. UNICEF has increased support for the provision of UBS for children and women. Beginning in Bangkok, the programme has been extended to major provincial cities and has incorporated PHC and income-generation components. Support for the expanded activities will continue in the current programme.

Children in especially difficult circumstances

114. Given Thailand's sustained and high level of economic growth, attention has been given to related social issues affecting children, including street children and working children. New programme initiatives have been developed with the Bangkok Metropolitan Administration and NGOs to ensure adequate protection and development of children in especially difficult circumstances, in keeping with the Government's commitment to these children.

Children in the hill tribes

115. An integrated training and programme package was introduced to hill tribe communities in the north, designed to improve the quality of life of geographically remote children and women. Significant progress is being achieved in the fields of health, nutrition, water supply and sanitation, crop cultivation and income generation. This project will continue to receive support in 1993 and 1994.

Advocacy and social mobilization

116. The Prime Minister of Thailand signed the World Summit Declaration on 12 March 1991 and Thailand acceded to the Convention on the Rights of the Child in February 1992. The Seventh National Social and Economic Development Plan (1992-1996) includes major emphasis on improving the quality of life of the most disadvantaged population groups and focuses on specific goals for children in especially difficult circumstances. The NPA incorporates the World Summit goals as well as additional goals specific to the situation of Thai children. UNICEF has been actively associated with these significant developments and has provided funding for national assemblies of children and women. Advocacy, programme-related communication and other mobilization activities will remain a key feature of the programme.

Breakdown of annual funding requirements

(In thousands of United States dollars)

| Region/country | Current programme cycle | Approved/ general resources funding a/ | Additional funding proposed | | | |
|---|---|---|---|---|---|---|
| | | | 1993 | 1994 | 1995 | Total |
| Africa | | | | | | |
| Benin | 1990-1994 | 4 455 | - | 949 | - | 949 |
| Botswana | 1990-1994 | 2 500 | 905 | 1 200 | - | 2 105 |
| Niger | 1990-1994 | 7 500 | 515 | 2 180 | - | 2 695 |
| Asia | | | | | | |
| Maldives | 1990-1994 | 2 416 | - | 430 | - | 430 |
| Philippines | 1991-1993 | 12 300 | 1 060 | - | - | 1 060 |
| Thailand | 1989-1993 | 1 200 | 900 | 600 | - | 1 500 |
| Middle East and North Africa | | | | | | |
| Egypt | 1990-1994 | 17 000 | - | 4 450 | - | 4 450 |
| Syrian Arab Republic | 1991-1995 | 2 500 | - | 1 000 | 1 000 | 2 000 |
| Total | | | 3 380 | 10 809 | 1 000 | 15 189 |

a/ The amounts shown here include the actual balances carried over from the previous programme cycle.

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FOR ACTION

# RECOMMENDATIONS FOR SUPPLEMENTARY FUNDING FOR PROGRAMMES IN THE AFRICA REGION WITHOUT RECOMMENDATIONS FOR FUNDING FROM GENERAL RESOURCES*

SUMMARY

The present document contains recommendations for supplementary funding for countries in the Africa region for which no recommendations for funding from general resources are requested at the 1993 Executive Board session. The programme proposals submitted here are aimed at expanding or complementing ongoing programmes in the countries concerned. The Executive Director recommends that the Executive Board approve supplementary funding in the following amounts for the programmes listed below, subject to the availability of specific-purpose contributions.

| Country/programme | Amount (United States dollars) | Duration |
|---|---|---|
| Côte d'Ivoire | 1 243 000 | 1993-1996 |
| Guinea | 725 000 | 1993-1995 |
| Zimbabwe | 9 289 000 | 1993-1996 |

Summaries of individual recommendations follow. A table setting out the planned annual phasing of expenditure for each supplementary funding proposal is given at the end of the document.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programmes cooperation at the end of 1992, will be contained in the "Summary of 1993 recommendations for general resources and supplementary funding programmes" (E/ICEF/1993/P/L.2 and Add.1).

# I. CÔTE D'IVOIRE

Basic data (1991 unless otherwise stated)

| | |
|---|---|
| Child population (millions, 0-15 years) | 7.4 |
| U5MR (per 1,000 live births) | 127 |
| IMR (per 1,000 live births) | 93 |
| Underweight (%, moderate and severe) | 12 |
| Maternal mortality rate (per 100,000 live births) | .. |
| Literacy (% male/female, 1990) | 52/32 |
| Primary school enrolment (%, net, male/female, 1990) | 58/42 |
| Percentage of grade 1 reaching grade 4 (1988) | 78 |
| Access to safe water (%, 1990) | 76 |
| Access to health services (%, 1980) | 30 |
| GNP per capita | $690 |

One-year-olds fully immunized against:

| | |
|---|---|
| tuberculosis: | 63 per cent (1990) |
| diphtheria/pertussis/tetanus: | 48 per cent (1990) |
| measles: | 42 per cent (1990) |
| poliomyelitis: | 48 per cent (1990) |

Pregnant women immunized against:

| | |
|---|---|
| tetanus: | 63 per cent (1990) |

Making health facilities "baby-" and "mother-friendly"

1. In 1992, the Executive Board approved a primary health care (PHC) programme for the period 1992-1996 as part of the country programme of cooperation for the Côte d'Ivoire (E/ICEF/1992/P/L.9). The programme addresses the development of PHC using the Bamako Initiative strategy and the gradual integration of expanded programme of immunization (EPI) and control of diarrhoeal diseases (CDD) activities over the period of the programme to reduce infant and child mortality and malnutrition. The PHC programme foresaw focused activities in six rural health zones and included a strong social mobilization element as well as monitoring and evaluation.

2. Although the Côte d'Ivoire has among the highest gross national product (GNP) per capita in the West Africa region, at $690, health indicators remain poor. The infant mortality rate (IMR) is 93 per 1,000 live births and the under-five mortality rate (U5MR) is 127 per 1,000 live births. The principal causes of child mortality are acute respiratory infections (ARI), measles, diarrhoea, anaemia, malaria and neonatal tetanus. Maternal mortality is estimated to be very high at 840 per 100,000 live births, with the main causes being haemorrhage, infections and obstetrical complications. Moreover, acquired immune deficiency syndrome (AIDS) is an increasing concern, with 5 to 10 per cent of the population being seropositive for the human immunodeficiency virus (HIV).

3. The Côte d'Ivoire made substantial investments in its health system in the past, particularly in the training of medical and paramedical personnel, as well as in the building of infrastructure. However, basic health care coverage for women and children remains poor as illustrated by still low immunization coverage (39 per cent for measles in 1992) and high mortality rates of young children. The inefficiency of the heal h system can be explained by the lack of adequate resources, owing partially to the decrease in the Ministry of Health operating budget. Even more serious is the poor management of existing resources and the lack of integration of different services. This results in low accessibility to health care for inhabitants of rural areas; low utilization of the system due to the poor attitude of the health care providers and poor quality of services (especially for maternal and child health (MCH) services). Other problems include the lack of budgets for drugs, inconsistent and unnecessary drug prescriptions caused by the absence of an essential drugs policy, and a non-functioning referral system.

4. The Ministry of Health, with the support of UNICEF and other agencies such as the Fonds d'aide et de coopération aux Etats de la communauté (Fund for aid and cooperation to countries of the former French community in West Africa) and the World Bank, has started to reorganize the public health system, emphasizing PHC activities in rural areas and reinforcing safe motherhood activities at the referral level. UNICEF support to PHC in six rural health zones includes the provision of essential drugs, the rationalization of health care services, community financing and community participation.

5. In 1991, the Côte d'Ivoire agreed to stop the distribution of free or low-cost infant formula in health facilities as one of the first test cases of a new agreement signed in 1991 with the World Health Organization (WHO) and UNICEF. The Government of the Côte d'Ivoire, together with WHO and UNICEF, has been taking active steps to implement the "baby-friendly" hospital initiative using the WHO/UNICEF publication "10 steps for successful breast-feeding" as a guide. By February 1992, four hospitals (including two university teaching hospitals) had achieved "baby-friendly" status as established by the WHO/UNICEF guidelines.

6. The evaluation of the pilot phase of the "baby-friendly" hospital initiative has shown how breast-feeding promotion was perceived positively by health personnel, as the proposed intervention was reinforcing the positive cultural aspects (such as rooming-in and support to human bonding) rather than underscoring the weaknesses of public health institutions. The initiative was also enthusiastically endorsed by the Ministry of Health, which wishes to go to scale rapidly in transforming all 86 hospitals in the Côte d'Ivoire to "baby-friendly" hospitals. However, public health authorities expressed their concern about isolating breast-feeding promotion from other child survival, protection and development activities and also from activities to support the well-being of women in general, arguing that hospitals where mothers die from haemorrhage and children from dehydration or measles could not be reasonably qualified as "baby- (or mother-) friendly".

7. This proposal, therefore, is designed to enhance and extend the current PHC programme to implement the WHO/UNICEF policy in support of breast-feeding on a national scale and to reinforce child survival, protection and development and safe motherhood activities at referral facilities and in urban areas not

already covered by the PHC programme. The proposal seeks to improve the effectiveness of health services through strengthening training and supervision activities at all levels using breast-feeding promotion and safe motherhood activities as an entry point, and by strengthening structures of participation and empowerment for improved household utilization of health activities.

8. This expanded PHC programme will aim to reduce low birth weight to below 10 per cent; reduce infant and under-five deaths due to malaria by 20 per cent; and reduce maternal mortality due to infections by 75 per cent, due to dysgravidia by 30 per cent and due to haemorrhages by 20 per cent. Among pregnant women, the expanded PHC programme aims to reduce anaemia from 60 to 30 per cent and to reduce the prevalence of sexually-transmitted diseases (STDs) from 40 to 5 per cent. The two main components of the proposal are activities to strengthen the health system and support to increasing access and use of health facilities by the poor in urban areas.

Strengthening the capacity of the national health system

9. The expanded PHC programme will support policy development for breast-feeding and safe motherhood at the central level, with mobilization activities to disseminate these policies through seminars for health workers and through the mass media for the general public. At the health facility level, standardized procedures and practices will be introduced in the areas of child survival, protection and development and safe motherhood, reinforced by training, improved supervision and the supply of basic equipment and essential drug kits. These activities within the formal health system will be complemented by the establishment of breast-feeding support groups in communities and the dissemination of information on safe motherhood to young women through women's groups and schools.

"Baby-" and "mother-friendly" urban health facilities

10. The current PHC programme explicitly addresses the priority needs of the rural areas of the Côte d'Ivoire. However, there are some emerging health problems related to increased urbanization (40 per cent of the population of the Côte d'Ivoire lived in urban areas in 1992) which are threatening mothers and young children. The decline in breast-feeding (in Abidjan, only 42 per cent of women continue breast-feeding for at least six months) is responsible for a large number of cases of diarrhoea and malnutrition. The increased transmission of AIDS is facilitated by the high rate of STDs among the total population (40 per cent of pregnant women reporting to health facilities have STDs), especially among migrant populations concentrated in the peri-urban slums.

11. The expanded PHC programme will focus on urban facilities in six towns associated with the six rural health zones supported in the current PHC programme and also on model "baby-" and "mother-friendly" facilities in two extremely poor communes close to Abidjan. In all these facilities, support will be given to staff to use the assessment-analysis-action (triple A) approach to review and plan for improvement in the delivery of health services, focusing on breast-feeding and safe motherhood. Through training, linkages with universities and other local institutions, clarification of national policy, collaboration with urban social workers and the creation of mother

support groups, the new approach will achieve the PHC objectives in the targeted areas. A total of 16 hospitals and 38 urban health facilities are targeted for improvement by 1996, with the training of over 240 health care providers. At least 16 community support groups will be formed, and information, education and communication (IEC) materials will be produced to distribute concise messages to the community (especially to young urban women) on safe motherhood and breast-feeding. These activities will complement support being provided to the health sector in the Côte d'Ivoire by the United States Agency for International Development for family planning, by the Governments of Germany and Japan for surgical equipment for obstetric referral facilities, and by the European Community for essential drugs.

12. Supplementary funding in the amount of $1,243,000 is requested for the period 1993-1996 to support the above activities.

## II. GUINEA

Basic data (1991 unless otherwise stated)

| | |
|---|---|
| Child population (millions, 0-15 years) | 3.3 |
| U5MR (per 1,000 live births) | 234 |
| IMR (per 1,000 live births) | 138 |
| Underweight (%, moderate and severe) | .. |
| Maternal mortality rate (per 100,000 live births) | 559 |
| Literacy (% male/female, 1990) | 35/13 |
| Primary school enrolment (%, net, male/female, 1990) | 34/17 |
| Percentage of grade 1 reaching grade 4 (1988) | 69 |
| Access to safe water (%, 1990) | 52 |
| Access to health services (%, 1980) | 75 |
| GNP per capita | $450 |

One-year-olds fully immunized against:

| | |
|---|---|
| tuberculosis: | 53 per cent (1990) |
| diphtheria/pertussis/tetanus: | 35 per cent (1990) |
| measles: | 90 per cent (1990) |
| poliomyelitis: | 33 per cent (1990) |

Pregnant women immunized against:

| | |
|---|---|
| tetanus: | 25 per cent (1990) |

13. In 1991, the Executive Board approved an education for all programme for the period 1991-1995 (E/ICEF/1991/P/L.8) as part of the country programme of cooperation for Guinea. This proposal is designed to enhance the current education for all programme to accelerate implementation of basic education for all in Guinea. Since the World Conference on Education for All in Jomtien, Thailand, in March 1990, heightened national interest in education has opened possibilities for accelerating implementation of education for all. This enhanced programme will build on these developments. It will also take into account lessons learned from innovative approaches attempted by the Government of Guinea to respond to the Jomtien challenges since the launching of the 1991-1995 programme. The proposed programme will address specifically the objectives of increasing school enrolment rates, particularly for girls; reducing drop-out rates; and reducing illiteracy.

14. The country covers an area of 246,000 square kilometres, with an estimated population of 5.8 million. Approximately 70 per cent of the population are under 35 years of age. It is estimated that in the year 2000, Guinea will have approximately 1,470,000 children between the ages of 7 and 9 years, or 16.5 per cent of the country's total population. It is further estimated that by the year 2000, Guinea will have approximately 1,000,000 children between the ages of 9 and 15 years, a large proportion of them being girls, who will have left school or who will have never been enrolled in school for various reasons.

15. The current country programme of cooperation began in the midst of an economic crisis that has sharply decreased government investment capacity. Although blessed with natural resources, including mineral deposits and climatic and soil conditions favourable for farming, Guinea is one the poorest countries in the world, with a GNP per capita of $450 in 1990. The Government, which has been under a structural adjustment regime negotiated with the International Monetary Fund since 1987, has failed to live up to all of the conditions of the agreement, such as privatization and the reduction of the civil service. A new agreement, called the Enhanced Structural Adjustment Facility Agreement, signed in 1991, requires the country to further trim the size of the civil service, continue the privatization programme, reduce public utility subsidies and respect promises of budgetary expenditure restraint.

16. Despite its financial constraints, the Government is keenly aware of factors that limit the development of basic education and is eager to address them. In September 1989, a national education plan was adopted, and following the Jomtien conference the Government committed itself to meet the challenge of providing basic education for all the Guinean people.

17. Factors that negatively affect the education system in Guinea include:

(a) The insufficient infrastructure for basic education which prevents most children from having access to school. In 1987, only 35 per cent of school-age children were enrolled nationwide (54 per cent in urban areas and 17 per cent in rural areas). In 1990-1991, enrolment increased by only 2 to 3 per cent;

(b) The quality of education suffers from a lack of basic equipment, supplies and didactic materials, as well as a limited number of trained and qualified teachers.

18. These constraints have caused a continued fall in enrolment rates throughout the country (31 per cent in 1984-1985 compared to 28 per cent in 1987-1988); a high drop-out rate, particularly of girls living in rural areas; and ultimately a high illiteracy rate (74 per cent of the population), particularly among girls and women for whom this rate reaches 86 per cent.

19. The present project aims to improve basic education quantitatively and qualitatively. The specific quantitative objectives are:

(a) To contribute to national efforts to increase enrolment rates of school-age children by 15 per cent per year;

(b) To contribute to national efforts to increase enrolment levels in functional literacy programmes by 15 per cent per year for parents, particularly mothers, and young girls;

(c) To contribute to national efforts to promote and reinforce community-based and affordable services at the preschool level, which will increase the chances for healthy growth as well as physical and psychological preparation for school of 50 per cent of children between the ages of 3 and 5 years.

20. The qualitative objectives are:

(a) To improve teaching conditions by reducing the teacher/student ratio and by preparing effective learning materials;

(b) To provide training for introducing appropriate methods and activities at preschool centres;

(c) To develop non-formal educational approaches for young people who have dropped out or have never attended school, particularly young girls.

21. The above objectives will be met through the following:

(a) The establishment of functional literacy and basic education programmes for adults, especially for women and girls;

(b) The development and establishment of education programmes for out-of-school children at the "Djamaa centres" (community schools or "schools for a second chance");

(c) The development and establishment of community-based early childhood and development programmes.

Djamaa centres or "schools for a second chance"

22. Based on a recently conducted feasibility study, UNICEF will support collaboration between interactive rural radio education programmes and the Djamaa centres. The aim is to carry out an experimental programme of basic education for about 30,000 children who are not enrolled in school. At least 1,500 young people currently without work will be involved in this activity.

Community-based early childhood and development

23. UNICEF will assist the Government, on one hand, to define and adopt a national plan for community-based early childhood development and, on the other hand, to establish 20 experimental community-based early childhood and development centres. This assistance will include support for the training of 40 new rural animators and 20 supervisors at regional management units; the production of didactic materials; and the provision of equipment and materials to the technical agents in charge of the management of the centres and supervision of trainers.

Functional literacy for women

24. UNICEF will provide support to introduce literacy and social education programmes at 100 newly established women's centres, which will be strategically chosen to allow them to be fully utilized by women's organizations, cooperatives and groups. Approximately 15,000 women and girls (between 4,000 and 5,500 per year) will be trained at these centres in three years. UNICEF assistance will facilitate the training of 72 trainers of the national literacy service, technical services and non-governmental organizations (NGOs). These trainers will in turn provide appropriate supervision and follow-up at the Djamaa centres. The project will also train 200 permanent trainers who will carry out literacy and post-literacy programmes to prevent recedivism among Djamaa centre trainees. UNICEF assistance will include the provision of teaching materials and mobile audiovisual equipment.

25. Supplementary funding in the amount of $725,000 is requested for the period 1993-1995 to support the above activities.

## III. ZIMBABWE

Basic data (1991 unless otherwise stated)

| | |
|---|---|
| Child population (millions, 0-15 years) | 5.4 |
| U5MR (per 1,000 live births) | 88 |
| IMR (per 1,000 live births) | 61 |
| Underweight (%, moderate and severe) | 12 |
| Maternal mortality rate (per 100,000 live births, 1988) | 77 |
| Literacy (%, male/female, 1990) | 74/60 |
| Primary school enrolment (%, net, male/female) | ../.. |
| Percentage of grade 1 reaching grade 4 (1988) | 84 |
| Access to safe water (%, 1990) | 84 |
| Access to health services (%, 1988) | 85 |
| GNP per capita | $620 |

One-year-olds fully immunized against:

| | |
|---|---|
| tuberculosis: | 91 per cent |
| diphtheria/pertussis/tetanus: | 89 per cent |
| measles: | 87 per cent |
| poliomyelitis: | 88 per cent |

Pregnant women immunized against:

| | |
|---|---|
| tetanus: | 51 per cent |

Support for child mortality reduction strategies

26. Child health has markedly improved in Zimbabwe since the country gained experience. However, IMR and U5MR are still high in comparison with many other countries. Present circumstances indicate that, without additional resources, the gains made until now may well be reversed and further reductions in infant and child mortality rates will be difficult to achieve due to drought, the social impact of the economic structural adjustment programme, inflation and AIDS.

27. The current devastating drought has cost the Government about $400 million on unplanned food imports to meet priority needs. This amount is almost three times the country's entire health budget for 1992, including the emergency child feeding programme. Even if the drought ends soon, its economic impact will be felt for some time.

28. Although the Government increased the health budget by 22 per cent this year under the economic structural adjustment programme, a 45 per cent inflation rate and the recent devaluation of the currency have reduced the real value of the health budget and raised prices, especially for supplies and equipment purchased from abroad. Over the last two years, real per capita expenditure for health dropped by 25 per cent, the lowest in five years.

29. In the past few years, the number of AIDS deaths among children has been rising. Sentinel surveys at antenatal clinics have estimated that in some areas up to 130 children per 1,000 live births may die of AIDS by their fifth birthday.

30. Due to all these factors, Zimbabwe will need a substantial increase in assistance in the health sector in the next three to four years. The Ministry of Health has recently completed its five-year plan for the period 1992-1996, with an emphasis on further improving MCH services.

31. The overall objective is to contribute towards achieving the goals of the World Summit for Children and the Zimbabwe National Programme of Action for children by reducing under-five and infant mortality and morbidity and enhancing proper child development in a sustainable manner. The major goals for children in the 1990s are to reduce IMR to about 40 per 1,000 live births and U5MR to about 50 per 1,000 live births.

32. The specific objectives of this project, which will run from July 1993 to June 1996, will be to achieve the EPI disease reduction goals; to reduce mortality from ARI, diarrhoea and malaria by one third; and to reduce perinatal and neonatal mortality by half. In order to achieve those objectives, the project will:

(a) Strengthen community-based health activities and community involvement in health care;

(b) Strengthen government capacity to reallocate existing resources for priority basic health programmes and use resources in the most cost-effective approaches to health care delivery;

(c) Assist the Government, NGOs and the private sector to identify ways of generating additional resources for basic health care.

33. The overall strategy will include the following elements:

(a) To empower families with relevant knowledge to better protect their children's health;

(b) To upgrade the knowledge and skills of all health workers in preventing and managing the most common causes of childhood mortality and morbidity;

(c) To provide supplies and equipment to enable health workers to utilize their training in preventing mortality and morbidity and improving service delivery;

(d) To support monitoring, evaluation and operational research activities in target areas.

34. UNICEF is presently funding a major study to collect information on the current activities of village community workers and their capacity to undertake further health work. Based on that study, UNICEF will assist the Government in formulating a plan to revitalize the workers by improving supervision and support, retraining and re-equipping existing workers and expanding the number to cover more areas. While village community workers will be the main focus, other village-level workers may also be assisted with training, educational materials or other inputs. One of the first steps will be to collect data on the experience of NGOs and other groups with community workers and to plan for the long-term sustainability of any new efforts.

35. With the current economic situation in Zimbabwe, efforts need to be made in the short term to better utilize available resources by all levels of the health sector, and in the long term to find ways to generate additional finances without placing an undue burden on the poorer sectors of society. In the spirit of the Bamako Initiative strategy, UNICEF will support research and pilot projects in community management and the financing of health units and other avenues for increasing revenues in order to provide directions for the Government on appropriate policies and strategies.

36. In order to maintain high coverage of immunization and achieve disease reduction targets, the following activities will be implemented:

(a) Improving coverage in low-coverage areas. National staff will work with provincial and district officials to resolve problems in areas where coverage is significantly below the national average;

(b) Improving disease surveillance and control, especially for neonatal tetanus and polio, through existing support under other UNICEF projects to the Epidemiology and Disease Control Department of the Ministry of Health;

(c) Purchasing polio vaccines and syringes, needles and sterilizers;

(d) Supporting the cold-chain system through the procurement of replacement cold-chain equipment, spare parts and supplies;

(e) In-service training of personnel in the cold chain and other EPI techniques.

37. CDD and control of ARI activities will include:

(a) Strengthening case management to reduce mortality;

(b) Educational activities for parents to enable them to identify signs of severity;

(c) Producing and distributing IEC materials for use at the community level;

(d) Preventing diarrhoea through hygiene education and better maintenance of water supplies;

(e) Operational research into alternatives for the sugar and salt solution.

38. The Ministry of Health is currently finalizing its plan to strengthen the national malaria control programme. UNICEF will support specific activities including:

(a) Training of community- and rural-based health workers in correct case management;

(b) Pilot projects on acceptability and appropriate channels for the distribution of insecticide-impregnated bed nets or cloths and similar forms of mosquito control;

(c) Support, including drugs, for testing the feasibility of chemoprophylaxis for pregnant women.

39. To reduce maternal and perinatal mortality, the basic strategy will be to improve access to and the quality of antenatal and post-natal care for mothers and children. To this end, the following safe motherhood activities will be pursued:

(a) To train traditional midwives to identify high-risk pregnancies for referral and to provide better delivery care for low-risk women who prefer to deliver at home;

(b) To provide basic equipment for rural health facilities and community-level workers to improve the monitoring of pregnancies and deliveries;

(c) To improve communications between rural health centres and referral centres;

(d) To conduct evaluation and operational research to identify areas for specific interventions.

40. UNICEF support for improving child nutrition will include:

(a) Addressing micronutrient deficiencies in the short term through the provision of vitamin supplements, notably iodine and vitamin A, to vulnerable populations;

(b) Supporting the National Nutrition Unit and other relevant bodies to develop a national nutrition policy in order to establish a framework to promote measures leading to household food security;

(c) Supporting community-organized preschool/child-care facilities;

(d) Expanding growth monitoring to the village level through training, equipping and supervising community workers.

41. The water supply and sanitation project will concentrate on expanding the role of existing water point committees to make them more responsible for water supply development and maintenance, health education and micro-environmental protection. In an effort to focus health education activities, environmental health technicians will identify risk behaviours associated with the most serious local water-associated diseases and plan activities in conjunction with the construction schedule.

42. This project will aim to complement services and activities already under way by the Government and NGOs with the support of UNICEF or other donors.

43. Supplementary funding in the amount of $9,289,000 is requested for the period 1993-1996 to support the above activities.

Estimated annual expenditure
(In thousands of United States dollars)

| Country/programme | 1993 | 1994 | 1995 | 1996 | Total |
|---|---|---|---|---|---|
| Côte d'Ivoire | | | | | |
| Making health facilities "baby-" and "mother-friendly" | 402 | 318 | 325 | 198 | 1 243 |
| Guinea | | | | | |
| Basic education | 275 | 250 | 200 | - | 725 |
| Zimbabwe | | | | | |
| Support for child mortality reduction strategies | 1 862 | 2 652 | 3 298 | 1 477 | 9 289 |
| Total | 2 539 | 3 220 | 3 823 | 1 675 | 11 257 |

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